New Jersey Department of Human Services
Division of Mental Health Services
Quarterly Newsletter "Wellness and Recovery Update"

The Stakeholder Summary
March 2007

Dear Mental Health Community,

Over the course of the past year, we've been updating you regarding efforts to steadily transition New Jersey's mental health services to a community system of care that embraces the principles of Wellness and Recovery. Following the recommendations of the Governor's Mental Health Task Force, we have been utilizing the "Stakeholder Participation Plan" as a vehicle to organize, plan and implement meaningful, effective, and long lasting systems change in three public, collaborative phases.

Having completed Phase I and issuing the Wellness and Recovery Transformation Statement on February 10, 2006, we began the Phase II, Planning Process. After many, many hours of work and input from several hundred stakeholders in 9 sub-committees and focus groups throughout New Jersey, DMHS held an event on March 2, 2007 to discuss the summary recommendations gathered by participants of the stakeholder process.

In keeping with the Division's efforts at transparency, attached is the summarized information gathered during the process, in both narrative and powerpoint presentation format. This was distributed to the consumers, family members, providers, and professionals who participated in this work. While this information is not a final plan, it represents what a broad base of stakeholders told us about important steps toward a transformed system of care. This information will be the basis for creating a document to guide our actions and commitments moving us to Phase III, Implementation.

This process has been an open dialogue with broad stakeholder participation. We hope that by sharing this information, the larger Mental Health Community will have the opportunity to keep abreast with our progress.

The leadership, guidance and inspiration that continued to be demonstrated during this phase reassure me that hope, optimism and momentum remain strong throughout our system.

Kevin Martone
Assistant Commissioner

Summary of NJ DMHS Wellness and Recovery Transformation Stakeholder Input Process

This is a summary of the stakeholder input process on New Jersey's public mental health system transformation effort. This document is an organized presentation of the input of over 120 stakeholders in 9 subcommittees (and in some cases, a breakdown into smaller subgroups within a subcommittee), as well as consumer focus groups examining the issue of transforming New Jersey's mental health system to one that focuses on wellness and recovery. The summary is divided into five chapters:

I. Consumer and Family Input
II. Evidence-Based Practices and Promising Practices
III. System Enhancements
IV. Staff Education, Recruitment, Development, and Retention
V. Data-Driven Decision Making/ Regulatory and Contracting Issues

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Chapter 1 focuses on the outcomes and service and system improvements consumers and their families reported will promote wellness and recovery. These were gathered through community and hospital based focus groups. Chapter 2 moves on to discuss the expansion of existing evidence-based services (e.g., integrated dual diagnosis treatment, supported employment, and illness management), as well as the introduction of new services that will promote wellness and recovery (e.g., Integrated mental health/primary health care and multi-family educational groups). These ideas were drawn from the input of consumers, families, and all other stakeholders involved in this process. In addition to new, expanded or additional services, stakeholders felt that there are system enhancements that can potentially foster recovery. Chapter 3 is devoted to these system enhancements, including improved information sharing, shared single Individual Recovery Plans, the removal of service redundancies, better community-hospital collaboration, and joint protocols with other systems, which can be used to foster wellness and recovery. Participant stakeholders felt that capitalizing on consumer input, implementing evidence-based and promising practices and enhancing the system would not be possible without an overall comprehensive program of staff development addressing recruitment, retention, education, and supervision. Chapter 4 outlines numerous workforce development proposals, particularly in the area of training and education. Chapter 5 evaluates the equally critical issues of how administrative structures and processes could foster recovery and wellness. It highlights data-driven decision-making, as well as other regulatory and contracting issues. Developing an infrastructure to collect relevant program outcome data will allow for the measurement of recovery-oriented and wellness goals, make possible program service evaluation, and help with the development of "report cards" for families and consumers. Additionally, this infrastructure will support the development of measures of fidelity to recovery orientation, contract compliance, and performance-based contracting. Furthermore, to promote wellness and recovery, revision of Medicaid and licensing regulations may be necessary, as well as changes in current contracting regulations. New methodology in performance-based contracting will need to be developed.

This summary does not address the viability or feasibility of the recommendations, all of which are being studied and assessed by NJ DMHS staff over the next several months. A final report, overall implementation plan, and specific work plans will be presented in the future.

I. Consumer/Family Input

The value of consumer and family input at every level of service development, provision, and monitoring was highlighted in virtually every subcommittee report. It is clear that all stakeholders believe that input from consumers and family members is integral to a system that emphasizes Wellness and Recovery principles. Consumer input was gathered through forums conducted in both the community and state psychiatric hospitals and family input was collected at the community forums. Additionally, consumers and family members were involved with other stakeholders on most of the committees. Described below is the direct input from the consumer forums, followed by recommendations regarding ways in which consumers and families can be better incorporated into a wellness and recovery-oriented system.

Definitions of Wellness and Recovery

Participants in the consumer forums articulated their understanding or definition of recovery and wellness. There was some overlap in these definitions, as well as a mixture of traditional understandings of "recovery" and consumer driven definitions of recovery. In general, wellness was understood by consumers to be related to taking care of oneself and a state of physical and emotional health. This was reflected in statements that defined wellness as, "a state of mind, attitude, staying drug free, keeping busy and getting enough nutrition, exercise and rest," and, "an overall condition of being healthy, not being emotional nor physically down."

Definitions of recovery varied more than did definitions of wellness. Many consumers identified more traditionally oriented definitions of recovery related to becoming free of symptoms and illness. In these statements, recovery was largely defined as the outcome of a process. These definitions were reflected in statements that described recovery as "recuperation from illness," "symptoms to disappear," and "medicine, stabilize, and get back to your life." Definitions that embodied a more consumer driven understanding of recovery identified recovery as a process and/or identified community supports as vital in this process. Examples of these definitions included, "learning about your illness, taking your time to get

better, getting enough love," "family support," "having supports in the community to stay out of hospital," and, "recovery you have to work on. If you do not work on it, it will go away. "

Consumers' Recommendations for Promotion of Wellness and Recovery

In the consumer, hospital-based forums several areas of recommendations were identified including: Improving Community Supports, Linkages, and Services; Improving Staff/Consumer Interactions; Improving Physical and Emotional Safety; Developing a Therapeutic Environment; and Developing Autonomy, Choices, and Personal Goals.

Improving Community Supports, Linkages, and Services

Having the necessary supports in the community to stay out of the hospital as well as the support of the community while in the hospital was important to consumers participating in the forums. Recommendations included significant system changes, such as "Better community services to prevent long-term hospital services." Additionally, suggestions were made to make upper management more accountable and accessible; "upper staff such as complex administrators and other such upper staff should be accessible or reachable to patients to deal with problems and issues that might arise and please listen, hear and try to understand." Consumers were also very concerned about "feelings of stagnation, feeling ready for discharge, but not being discharged." "There needs to be a way to get patients out of the hospital faster."

Consumers identified the need to improve linkages between inpatient and community aftercare. They pointed to poor follow-up and a sense of "being lost in the system and the system's lack of follow-up with you." Recommendations to improve the transition from inpatient to community care included making sure each consumer has a doctor in the community prior to discharge, scheduling several community agency appointments in advance, providing information on community agencies that can be contacted, and assisting with Section 8 and Social Security paperwork. Some consumers were concerned about "easy access to alcohol," "friends that like to drink," and "peer pressure", so assistance with addiction services

and connecting consumers with their community twelve-step programs was recommended. The forums also recommended strengthening ICMS and PACT services, as well as offering additional support groups, resources, general support, individual therapy and personalized treatment plans.

Consumers were concerned about the stigma related to mental illness and the impact of this stigma on services received from public service employees. The forums recommended better linkages between inpatient and outpatient providers, improved training for police and mental health screeners, more staff at community agencies, an increase in emergency 911 cell phones, and the establishment of a 24-hour community agency live contact person that is available to be contacted anytime for a ride, support, or just to "vent." Additional education on mental illness was suggested for both the general public and persons working in the mental health field.

Lack of employment, transportation, and housing were identified as barriers to remaining in the community. Consumers noted a desire to complete their GED or other educational goals. They also specified that employment opportunities are needed for persons while they are in the hospital. Furthermore, financial problems resulting from unemployment and a poverty of work opportunities were listed as barriers to employment as was transportation (e.g., not having a car or driver's license). In relationship to housing, some individuals identified the need for more group homes while others were interested in a place to live on their own.

Improving Staff/Consumer Interactions

The interactions between staff and consumers were an overwhelming concern in the forum comments. Consumers perceive that direct care and professional hospital staff do not have empathy, care, or respect for them. One consumer reported, "The staff is mean, rude, fresh, curses at you, yells at you and obnoxious. The staff yells at you all the time and this causes depression." Another stated, "There is no communication between me and the staff." Professional staff are seen as unapproachable, insensitive, impatient, and uninterested in the consumers as human beings and individuals. Forum participants

recommended that staff be “more caring and understand patients” and offer hope to consumers through better communication. Other recommendations included making the hospital “a calmer place”, professionals and staff being “receptive to needs”, treating consumers with respect, and everyone being nurturing, caring, and understanding. Another finding was that many consumers expressed that staff had a lack of concern, failed to offer help with, and/or understand that consumers still had to take care of personal business in the community while hospitalized. Consumers cited, “make sure people don’t lose things in the community,” while they are in the hospital. They suggested, “Create a business day – a day out of the hospital to handle bills and other things.” Worries over children, rent, legal issues, bad credit, and families could be handled through effective community connections and support services.

Physical and Emotional Safety

A lack of physical and emotional safety from peers was a concern identified by several consumers in statements such as, “hustling, borrowing, gambling, trading, selling and buying.” Several comments were made about having “bullies on the unit.” In the varying contexts of this comment, some individuals were referring to fellow patients, and some were referring to staff. One person reported being given a black eye by a peer. Other people commented on peers not being motivated or being too negative. Another consumer’s concern was whether staff would be able to “Keep me from hurting myself.” Perhaps most strongly stated, “It’s very unstructured and unorganized.” Several consumers recommended that consumers be grouped by diagnosis/ functioning level.

Therapeutic Environment- Improved Treatment Activities

Consumers were clear about their need for therapeutic activities while in the hospital. They noted isolation, noise, boredom, and a lack of appropriate activities as barriers to their recovery. Consumers report that medications are the main focus of current interventions, and identify that they need more psychological service/help. Recommendations from the forums included additional 1:1 therapy, employment activities, music/game rooms, outdoor activities, more exercise, and educational movies.

While some consumers requested additional groups for specific issues (e.g., women's groups, trauma groups), others advocated for more relaxation time (less "forced" socialization). Community transition, including activities like shopping, community bingo and bowling, was another area where some consumers thought additional groups would be helpful. Being able to attend the church of their choice as a "level three" to meet spiritual needs was also recommended.

Improving physical aspects of the environment, such as better lighting and painting the walls in the bedrooms was recommended. Consumers were interested in improvements that would make the environment feel calmer. Individual items that could help consumers accommodate to the environment, such as earplugs, dental floss, and hygiene products, were also recommended in the forums.

Autonomy, Choices, and Personal Goals

"Constantly having people in charge of me, isolation and seclusion," were concerns noted in the forums. Consumers have little choice over small things such as phone calls, wake up times, meals, or when to meet with the treatment team. The forums recommended increases in choices.

Overcome Personal Barriers– Self-management

Some consumers identified their own behavior or symptoms as barriers to wellness and recovery, both in the hospital and in the community. For example: "For me it's voices," "Symptoms," "Not taking medications, and keep hurting myself," "Not following through," "Substance abuse, irresponsibility, lack of self motivation," "Going around old people, places, things. Always thinking the negative." While these consumers implicitly or explicitly acknowledged that taking responsibility for their actions and illness is important for recovery to occur, these comments also reflect a level of hopelessness and isolation in their experiences.

Building and maintaining relationships with others was another area where individuals noted barriers to their recovery. For some this was apparent in a "lack of friends" while for others it was manifested in family issues. "Family not understanding or desiring to be educated about mental illness

being a life long process," was reported by one consumer. Others had problems with information not being shared with family members or with stigma in the community.

Consumers and Families in a Wellness and Recovery-oriented System

In addition to the concerns and barriers identified by consumers and families as described above, recommendations for the involvement of consumers and families in a transformed system were made. The following areas for consumer/family input and involvement were identified:

- Treatment Planning and Support
- Staffing decisions
- Resource Allocation
- Data Driven Decision Making (addressed here and in Chapter 5)
- Methods of Disseminating Information

Treatment Planning and Support

Several reports noted the importance of involving family members in wellness and recovery planning. Additionally, the recommendation was expanded to include the input of significant paid and unpaid supporters, that is, people consumers identify as important in their lives. These individuals should be included in all aspects of service planning, care, and evaluation. Perceived barriers presented by HIPAA and state confidentiality laws need to be addressed proactively to more fully include family members and significant others.

Staffing Decisions

Of particular importance is the issue of consumer and family input into staffing and supervision. It was suggested repeatedly that a mechanism for consumer input into hiring, supervision, and firing decisions be developed. The recommendation was to include consumers and family members as part of the interviewing process, and incorporate their input into the development of staff evaluation plans.

Resource Allocation

Recommendations for consumer and family input into resource allocation decisions were also made. A specific suggestion to include more consumers and families on county mental health boards and other committees was proposed to increase their statewide input into the development and evaluation of programs and services.

In addition, it was recommended that the Division encourage DMAHS to expand flexibility in funding toward the goal of providing individualized, consumer chosen services in the least restrictive appropriate settings. It was also suggested that the adequacy of consumer/family representation on board and policy-making groups be evaluated.

Data-Driven Decision Making

As part of a larger Data Driven Decision Making model, it was recommended that mechanisms be developed to regularly collect consumer and family input. The use of surveys was proposed in which resulting feedback would be incorporated into operational decision-making. Furthermore, it was recommended that consumer satisfaction teams administer surveys in order to increase the likelihood of genuine responses. “Report cards” regarding service performance could also be developed and shared with consumers and their families. Data driven decision-making is more fully addressed in Chapter 5.

Methods of Disseminating Information

In order to keep consumers and family members informed of decisions made regarding the implementation of practices, the availability of resources and the evaluation of services, it was recommended that consumer advocacy educational forums be developed. In addition, it was suggested that a consumer dedicated website be developed to provide information and solicit input. An informational newsletter to provide updates on the transformation, including consumer written articles, was also proposed. Finally, it was recommended that ongoing consumer and family input be solicited via written comment on specific issues using focus groups and consumer survey information.

II. Evidence Based and Promising Practices

Consumers, families and other stakeholders made numerous recommendations for the introduction and expansion of established evidence-based practices and the fostering of promising practices that are likely to promote wellness and recovery. These recommendations include suggestions regarding implementation, monitoring and training. Although there is a specific committee designated as the Evidence Based/Promising Practices Subcommittee, recommendations regarding Evidence Based Practices (EBP) and promising practices appeared throughout all of the committee reports. It is evident that these practices are considered important by all stakeholders for the transformation to a Wellness and Recovery oriented system. One committee included in its report the following statement,

> "An ideal system is one that is recovery oriented, includes access to a full array of evidence based practices as well as an array of programs that are best practice models" (Systems Subcommittee, pg. 2).

The recommendations provided throughout the subcommittee reports that pertained to Evidence Based and Promising Practices can be organized under the following categories:

- Core Competencies for EBPs, (which will also be addressed in Staff Development, Chapter 4)
- Training in Specific EBPs (also covered in Staff Development, Chapter 4)
- Introduction of New Promising Approaches
- Funding and Regulatory Issues, including Monitoring

<u>Core Competencies for all EBPs and Training in Specific Practices</u>

The overwhelming response from all subcommittees that addressed EBPs and Promising Practices was that a competent workforce was a necessity for the successful implementation of those practices. It was recommended that administrators, supervisors, and practitioners delivering the EBPs and Promising

Practices must possess the specific competencies outlined in the research literature, understand the use of fidelity scales, and use toolkits as available in the following areas:

- Illness Management and Recovery (IMR)
- Assertive Community Treatment (ACT/PACT)
- Integrated Dual Diagnosis Treatment (IDDT)
- Supported Employment
- Family Psychoeducation
- Motivational Interviewing
- Peer Support and Self-Help
- Cognitive Behavioral Therapy (CBT)
- Supported Education (SEd)
- Supported Housing (SH)
- Wellness and Recovery Action Plans (WRAP).

In addition to the aforementioned EBPs and Promising Practices, training for mental health clinicians in Stages of Change/Recovery model of readiness was also recommended because of the application of this model to so many areas. It was noted that training packages should be user friendly and sites should be chosen as centers of excellence to pilot the materials. In order to ensure the adequacy of trainings, it was recommended that the state collaborate with professional societies and academic institutions for training and certification of the workforce. Training recommendations are discussed in more detail in the Staff Development chapter, Chapter 4.

Implementation, Funding and Regulatory Issues

The subcommittees acknowledged that in order to prepare the workforce for the implementation of EBPs and Promising Practices, several things would need to occur. First, any current training programs on the EBPs and Promising Practices will need to be expanded. Second, it was recommended that DMHS and other state level partners should support and expand EBP and Promising Practices while embracing the utilization of scientifically derived fidelity scales to maximize service outcomes and efficiency. Additionally, it was noted that collaboration between NJ DHS and NJ DOL could expand EBPs and Promising Practices like supported employment (SE) and supported education (SEd). Lastly, collaboration with the NJ Division of Medical Assistance to address Medicaid funding of EBPs was also suggested.

Several of the subcommittees also addressed the funding and regulatory issues that would affect the successful development and implementation of EBPs and Promising Practices. It was recommended that DMHS provide seed money and develop training and implementation plans that will lead to the expansion of programs and services in SE, SEd, Family Psychoeducation and Evidence Based psychotherapy approaches such as skills training and Dialectic Behavioral Therapy (DBT).

For approaches that already receive funding, a recommendation was made that the fidelity of those programs to the principles of their specific services, as well as wellness and recovery principles be evaluated. For example, several recommendations regarding the provision of employment services were made. It was suggested that the full array of employment services that constitute the EBP of SE be funded (e.g. coaching, readiness, role plays, interviewing skills, interacting with community employers). In addition, long term or follow- up employment services need to be recognized and funded as an integral part of an individual's occupational success. Therefore, support for maintaining jobs and skills teaching around problem solving, emotional support, and crisis resolution should be reimbursable.

In addition, regulations will need to be changed and incentives will have to be provided to clinicians to seek training. Finally, credentials for specific training in the EBPs and Promising Practices would need to be developed and offered.

Monitoring of EBPs and Promising Practices to Promote Wellness and Recovery.

Several recommendations were made on the training and monitoring issues that implementation of the EBPs and Promising Practices would require. The development and provision of training and technical assistance on the specific EBPs, following the model used in several states, (including monitoring of fidelity to the model) was suggested. In terms of ongoing assessment and monitoring, it was recommended that fidelity tools be used and quality indicators and data collection systems at the state level be developed. Finally, an Advisory Committee to assist DMHS in its efforts to implement, expand, and monitor practices was proposed. Additional regulatory changes are discussed in Chapter 5 below.

III. System Enhancements

To complement new and expanded services, stakeholders felt that improvements to the current service systems would contribute to the development of a wellness and recovery-oriented system. Many recommendations in this area address obstacles identified within the service system. A system-wide needs assessment should be conducted to identify service gaps and provide a statewide report. Funded agencies should be required to inform consumers and families of the full array of available services and exclusionary criteria for services should be eliminated. It was recommended that providers serving the same individual be required to share data. In this way, a single Individual Recovery Plan would replace the multiple treatment plans currently required by varying service regulations and an essential medical/treatment record, perhaps of an electronic nature be maintained and shared.

Evaluation of Current System

The subcommittees begin their recommendations for system enhancements by identifying mechanisms to evaluate the system as it currently exists. Systems Mapping was recommended as a tool

that can be used to compare the existing system with an ideal system designed by stakeholders. The goal would be to establish a baseline assessment of the current system and then to identify where systems' change and improvements need to occur. Additionally, it was recommended that a baseline of consumer satisfaction and a method for ongoing systems' evaluation be established. To this end it was suggested that the Recovery Oriented System Indicator (ROSI) be utilized to survey the current system. In order to ensure the most accurate data is collected, consumers should be trained and hired to administer the instrument. The results of the ROSI should then be used to identify areas of strength to be replicated in the future, and areas of need that the system must address.

Lastly, in this category it is recommended that groups be convened to evaluate the potential for service duplication in the current system. In particular it is recommended that the Integrated Case Management Services (ICMS) program be evaluated. With this type of evaluation it may become evident that there is duplication of services and that funding can be redirected to support the development of new positions identified elsewhere in this document as well as community support teams. It is further recommended that regulations be revised to clearly articulate the extent to which individuals can participate in multiple programs without duplicating services.

Treatment Philosophy and Service Provision

Beyond suggestions to evaluate the current system, the subcommittees have made recommendations for future enhancements to the system. The recommendations of the subcommittees are based on an overall treatment philosophy of wellness and recovery. Recommendations to support this treatment philosophy were identified with multiple suggestions for the development or expansion of services, in addition to those outlined above in Chapter 2. First, it was recommended that DMHS communicate throughout the system that the language, attitude, and environment of all agencies be based in "people first" values and philosophies. Additionally, a recommendation to support this philosophy was the use of outcome oriented-contracting to encourage a shift from the medical model to supported socialization

focusing on the development of skills to support integration into community living. It was further proposed that treatments and interventions should focus on building supports within self, family, and community to develop relationships and support community integration. Therefore, programming should be specifically designed to meet the real life goals and needs of consumers through assuming real life roles. Finally, this philosophy should also extend to interactions with psychiatrists and all staff such that a collaborative model and approach will be used.

Documentation

In order to best document supports and services offered in a transformed system several recommendations were made. One such recommendation was the incorporation of The Virtual Individualized Electronic Wellness/Recovery Action Plan (The VIEW). The VIEW is envisioned as a software tool that can be developed to create an electronic record for each consumer receiving services. The VIEW would include a description of goals in the various life domains including housing, transportation, employment, education, self-advocacy, and others. Additionally, the VIEW would incorporate an advanced directive and input from the consumer, his or her family and significant others, and treatment/support staff. The VIEW could ensure an accessible integrated approach to those receiving multiple services. In order to realize this recommendation hardware and software would need to be purchased, training would need to take place, protection of access to the information would need to be established, and public forums would need to be held to evaluate the use of this type of technology. It was recommended that a RFP be published to invite experts in the field to respond to identified needs. As mentioned above, a recommendation was made for a single Integrated Recovery Plan (IRP) for each consumer to replace the multiple treatment plans currently required for individuals in multiple programs. Lastly, it was recommended that the Division develop and mandate uniform Wellness and Recovery strength-based, program specific documentation requirements.

Advance Directives

It is recommended that training and education regarding the use of advance directives must continue and reach all stakeholders, especially at the crisis end of the continuum. It is also suggested that advance directives be reviewed to ensure they will be honored in a time of need. It is further recommended that the advance directives be incorporated into the VIEW and that the navigator and peer educator positions (discussed further in Chapter 4) be used for training and education on this topic.

Joint Protocols and Cross Training

The subcommittees made recommendations related to individuals who are currently working with multiple service users. It was recommended that there be shared responsibilities for these individuals through joint policies/procedures, protocols, and service affiliation agreements approved and supported by the DMHS. Additionally, joint and cross training should be available for providers of services for the shared populations. Lastly, data sharing should be required for consumers who are involved in shared services.

Community Education

To support the overall philosophy of wellness and recovery, DMHS should develop a public education campaign that brings a positive mindset to the general public, professionals, and potential employers. This could be addressed through the funding of a widespread anti-stigma, public information and education campaign. Education to several communities are specified including, the medical community, legislators, and developers of college curricula.

Access: Point of Entry

The subcommittees addressed concerns regarding potential barriers for full access to needed services. The subcommittees recommended that access to services be evaluated so that individuals do not need to be hospitalized prior to being eligible for enrollment in certain programs. It was suggested that funding, policies/procedures, affiliation agreements, and staff training be examined to make services available and accessible to consumers based on their need rather than point of entry. Additionally, it was

recommended that a mechanism be developed for “no wrong door” so that there is a single point of entry for all services needed: physical, social services, vocational, educational and other needs that span system boundaries. It was further suggested that exclusionary criteria be eliminated for all agencies. Lastly, it was suggested that multi-systems referrals be monitored to confirm that staff are matching consumers with needed services.

Access: Housing

An additional area of recommendations made by the subcommittees was related to access to necessary housing supports and services. One recommendation was to develop and maintain an information/clearinghouse to improve access to housing, and assistance with getting housing. Furthermore, it was suggested that a wide spectrum of housing and programs should be offered within all levels of the system. Lastly, emergency assistance and housing subsidies should be made available at all levels of care, particularly for independent living situations, as a safeguard.

Access: Other

It is recommended that time with psychiatrists and APNs be increased. It is recommended that in order to improve consumer access to faith based organizations agencies should develop affiliations with local community faith organizations.

Other Service Enhancements Discussed

In accordance with a wellness and recovery treatment philosophy recommendations for specific services and skills teaching activities were made. First, it was suggested that a learning academy be developed and implemented for consumers in which various socialization issues are addressed (e.g., making eye contact, seeking and developing friendships, conversation, illness management and relapse prevention, and development of skills to combat stigma). Second, the development and implementation of a training curriculum for consumers regarding use of the social service system is also recommended. Thirdly, agencies should provide the education and life skills management that would be needed to live

independently and sustain housing in the community. In addition, it was recommended that agencies provide families and consumers with education regarding use of the Americans with Disabilities Act, NJ Anti-Discrimination Law and other related legal concerns. Lastly to ensure use of these services, it was recommended that services be available during the hours consumers most need support: holidays, weekends, and after hours, and access to transportation be improved through the use of bus passes and consumer operated transportation.

IV. Staff Development: Recruitment, Retention, Education, & Supervision

Implementing EBPs and promising practices, as well as service system enhancements will require a highly competent workforce Recruitment, retention, and continued development of a qualified, competent, caring workforce was identified as essential to the success of the Wellness and Recovery Transformation Initiative and identified by not only the workforce subcommittees, but the majority of the other committees as well. According to one consumer participating on a subcommittee, the system must:

> "Find ways to hire staff who are compassionate and knowledgeable and find
>
> ways to eliminate staff who can't '*get*' wellness and recovery."

Resulting recommendations are organized under the following categories: 1) recruitment and retention, 2) methods for increasing staff competency: standardized curricula, 3) training for Evidence Based and Promising Practices, 4) training for supervision, 5) educating consumers as providers, and 6) recommendations to hospital settings.

Recruitment and Retention

Several subcommittees suggested that staff recruitment and retention, especially in community agencies, would be improved by creating parity between state and community provider salaries and benefits. Maintaining an annual cost of living adjustment on salaries was also recommended as a method for improving staff retention. Connecting academic and credential development to staff salary differentials

was another method recommended for improving retention and contributing to staff development. Creation of career ladders or paths would also promote staff growth and retention.

Several subcommittees made credentialing recommendations that would affect staff recruitment and retention. Making the Certified Psychiatric Rehabilitation Practitioner (CPRP) a preferred credential and having it available to direct care staff who choose to participate in a work-related educational program were among the recommendations. A pre-paid tuition reimbursement program should be made available for participation in such programs. Related to this latter recommendation was that existing academic programs available at some state psychiatric hospitals be expanded to all hospitals and that staff be allowed to attend classes using flex time. Likewise, upward mobility should be available for direct care staff who obtain their CPRP or other relevant recovery-oriented credentials or certifications. It was also recommended that programs be required to have a minimum number of CPRPs on staff.

Several reports offered the following suggestions for recruiting and retaining individuals with a likelihood for success in a Wellness and Recovery oriented system: involving consumers in staff interviewing, hiring, supervision, and firing decisions; establishing liaison positions within DMHS or using other designees to connect with local colleges and universities for the purposes of recruiting students and influencing curricula; and providing funding for supported education and credentialing opportunities for consumers. Other recommendations for recruitment included creating a centralized website for mental health job openings and promoting knowledge of the loan forgiveness program. It was also suggested that state and local agencies use exit interviews to determine reasons for staff resignations and terminations, and then use that information in quality improvement efforts.

Methods for increasing staff competency: Standardized curricula

The subcommittees overwhelmingly recommended the use of standardized curricula to teach Wellness and Recovery, Evidence Based Practices, and Core Competencies needed for service delivery. Development of curricula and subsequent training should be done by local academic entities, subject

matter experts (SMEs) from centers of best practices, and nationally known experts. Using consumers and family members as primary presenters was also recommended. These persons should be selected for their topical competency as well as their personal experience. There were contrasting recommendations on whether training should be centralized and coordinated or on-site and customized. The latter recommendation noted thin staffing patterns that do not allow staff time away from their worksite for training. Several subcommittees made recommendations for technical assistance follow-up or other consultation to assist with implementation and to provide monitoring.

It was recommended that "Core" courses be approved for state licenses and national certifications. The expansion of training programs and installation of incentives were recommended so that clinicians will seek training and credentialing. For example, staff would be allowed to use flex time for attending school.

Regular evaluation of clinician competencies and practices was also recommended. Competency was identified for both individual clinicians and organizations. For example, one recommendation was that additional training be used as the first line of remediation for underperformance. Another suggested that provider competency be established as an outcome.

The subcommittees recommended that an initial general Wellness and Recovery training be followed by more specific, targeted trainings. Existing staff were recommended as a priority for first-line training, followed by new employees. The promotion of active listening, engagement, motivation, and "people-first" values and philosophies through training was emphasized. Other areas recommended for training included financial entitlements, Section 8, medical benefits, cultural diversity, the impact of mental illness on the overall quality of life, service matching, spirituality as a focus in wellness and recovery interventions, and a shared decision making model. Training for accessing faith based community resources was also noted.

The infusion of Wellness and Recovery into all state funded training, regardless of provider, was a common recommendation, for example, Wellness and Recovery training for Division of Vocational

Rehabilitation staff. Recommendations for cross training of staff who work with various groups of individuals was made, specifically staff working with persons with development disabilities, “aging in” adults, people in the criminal justice system, individuals involved with addictions services, and elderly persons. For example, staff working in the criminal justice system would receive IMR training. Another systems recommendation for trainings was for joint wellness and recovery training for shared populations, such as hospital and community providers, with the aim of improving communication and working relationships.

Two Workgroups developed detailed recommendations for the content of Core Competency curricula for both community and hospital staff. These are attached in Appendix A.

Methods for increasing staff competency for Evidence Based and Promising Practices

Staff who deliver evidence based and promising practices must possess specific competencies for their particular practice. It was recommended that the state work with professional societies and academic institutions responsible for certification to establish a training and technical assistance infrastructure, including E-learning, to train staff and promote the use of EBPs and Promising Practices. The recommendation includes simple, concrete and easily replicated training packages, as well as mechanisms for monitoring fidelity and outcomes. Furthermore, the subcommittees recommended that “centers of exemplary practice” be established in programs that operate with a high fidelity to specific EBP models so that these may be used as training and consultation sites. Establishment of a coalition of agency leaders to promote identified EBPs was also recommended. Ongoing evaluation of these projects should be conducted at the state level.

Specific recommendations were made for some EBPs. For example, employment programs should have a training program specifically for benefits counseling. Job shadowing at high fidelity programs was recommended as a training strategy for newly hired Supported Employment staff. The subcommittees also recommended that Family Psychoeducation include a full education and training initiative to support the implementation of Advance Directives. One subcommittee advocated for using incentives and training for

programs with services that approach EBP Multi-Family Psychoeducation Groups (MPFG) practices. They also suggested a planned conference on MFPG.

Methods for increasing staff competency: Supervision

Individual and group supervision were identified as methods for increasing staff skills, competency and adherence to Wellness and Recovery principles. Skill-based, non-punitive supervision reinforcing the need for honest, compassionate, and moral communications was recommended. Individualized learning plans were suggested as a method for identifying staff competency needs and monitoring development. Basing performance appraisals and evaluations on Wellness and Recovery principles was recommended. In the hospitals, it was recommended that immediate supervisors develop initial performance evaluations for new employees and incorporate these into employee PAR/PES. The Hospital Subcommittee also suggested a "person-in-recovery" survey tool to measure staff application of Wellness and Recovery principles.

Consumer/Family as Providers, System Navigators and Peer Educators

The recommendations made in this area emphasize the importance of increasing the number of consumers and family members who are present in the system as service providers and trainers/educators. It was recommended that a position be created for a navigator who would be a member of a community support team. The navigator would be a peer/family member and he or she would assist consumers with navigation of the system. The position would help assure access to programs and support services needed to meet consumers' goals as identified in the VIEW, a proposed electronic medical record discussed previously in Chapter 3. A peer educator position should also be created. The peer educator would be a consumer or family member and would provide self-help training and mentoring, as well as assisting with the development of advanced directives. The duties of these positions must be clearly defined, funding must be identified, credentials established, and training and oversight provided to ensure there is no duplication of services. Additionally, DMHS should fund opportunities specifically for peer providers at all

levels of the system. The opportunity for mental health consumers to provide mandatory training on mental health issues for all members of the workforce including hospital and community emergency personnel is recommended. It is important, however, that all family members and consumers who are hired to provide these services be competent.

Recommendations Specific to State Hospitals

The Hospital Subcommittee recommended that DMHS contract with an academic entity to develop standardized core training and EBP and promising practice trainings for use with all hospital and central office staff. The academic entity would conduct train-the-trainer sessions for the DMHS training coordinators. These training coordinators would then offer ongoing access to training for new and existing hospital and central office employees. Ongoing support and technical assistance would be available to training departments through the academic entity or consultants.

Content identified for training by the Hospital Subcommittee echoed many of the recommendations from the community. Additional recommendations unique to the Hospital Subcommittee included content for the Hospital Core training curricula. Basic therapeutic skills, accountability, communication skills, and supervisory training were recommended for hospital staff. It was also recommended that staff safety and security be addressed as Wellness and Recovery is introduced, and that all staff receive the hands-on training "needed to ease the transformations process." Core training for leadership and executive staff at the hospitals was suggested, including mentoring, team building and succession planning. Efforts should be focused on leadership so that training and orientation translates into Wellness and Recovery oriented hospital policies and practices. Training and technical assistance for holding effective meetings was also suggested for treatment teams.

The Hospital Workforce Subcommittee suggested that it continue meeting to further its work on competency development and serve as a technical resource and quality improvement mechanism for the Initiative. A quarterly joint meeting between the Workforce Development Subcommittee and hospital

representatives should be held to troubleshoot and discuss issues with the training plan and related concerns.

The allocation of adequate resources and additional training positions for FY2008 to achieve workforce objectives, that is, comparable training departments in terms of available trainers, consultants, and resources available, was recommended. All state psychiatric hospitals should have a consistent staff development plan. This plan should heighten the awareness of Wellness and Recovery oriented approaches for existing staff. Data collected during the Workforce Subcommittee's survey should be used to determine staff training needs and evaluate staff improvement. A recommendation was made for monitoring and re-evaluation by DMHS within one year to ensure that the Wellness and Recovery approach is maintained. Another suggested that DMHS assume full responsibility for all aspects of Wellness and Recovery training within one year of contracted services.

Policy and procedure changes

Some needs for training will result from policy and procedure changes, new program implementation, or creation of new positions. For example, initial and ongoing training is recommended for: 1) data collection and reporting for all Division funded agencies and hospitals, and 2) the use of electronic records. One significant recommended policy change, the ability to access services based on need rather than location, that is, without hospitalization, will require training for all parties. Also, the outcomes evaluation, contracting and regulatory changes described below in Chapter 5 will require significant training.

V. Data-Driven Decision Making, Regulatory and Contracting Changes

Critical to all the recommendations outlined above will be the appropriate administrative structures and processes to support the wellness and recovery transformation effort and the sustaining of the wellness and recovery-orientations. The relevant subcommittees addressed recommendations for inter-related changes in contracting, regulations, and outcome measurement. The recommendations across

subcommittees consistently reflected the themes of establishing measurable outcomes relevant to wellness and recovery. These include:

- Developing an accurate and relevant data collection system
- Using the data collection system to evaluate service outcomes
- Informing the contract reimbursement process after performance data system has been established and baseline information collected
- Providing service performance information to people with psychiatric disabilities and family members
- Ensuring consumer input into the development of a wellness and recovery system including its funding decisions.

Establish Measurable Outcomes to Facilitate Data-Driven Decision Making

It is recommended that DMHS operationalize its model of New Jersey's transformed system including an articulation of its own role. This process could be informed by consultation from other states that have successfully made progress in such a transformation effort. To do this, it will be necessary for DMHS, in consultation with providers, participants, and experts, to identify system goals and create associated outcome measures that are specific to individual consumers and program modalities, and are indicators of systemic change. It is also recommended that DMHS, in consultation with the aforementioned groups, identify and/or create fidelity measures for each modality that will assess their faithfulness to both the program elements and wellness and recovery principles.

Develop an accurate and relevant data collection system

It is recommended that DMHS develop the capacity, infrastructure, and funding to support statewide data collection and analysis that is consistent with the system transformation goals. This should include the establishment of baseline data to support future outcomes evaluation efforts. Furthermore,

DMHS should provide initial and ongoing training regarding data collection and reporting for all their funded and partially funded agencies and hospitals.

Develop a Database of Overall Health Indicators

It was recommended that data related to physical health and wellness service needs, availability, and effectiveness be collected and tracked on a regular basis. In addition, a request should be made to Medicaid to share information on people receiving medical services. Assessments should be conducted to examine the success of referrals and linkages. An analysis of the mortality/morbidity rates also needs to be conducted. DMAHS should be encouraged to expand flexibility of funding to promote individualized, consumer-chosen services in the least restrictive appropriate settings.

Evaluate Service Outcomes/ Based Funding on Performance

It was recommended that DMHS embed wellness and recovery outcome measures in all inpatient treatment services and community contracts with data reported on a timely basis by all funded and partially funded agencies. Measures should also be taken of consumer satisfaction and consumer–driven goal achievement. These outcomes should be reflected in the Annex A requirements.

Documentation requirements to assure compliance should be reflected in the regulations. Several recommendations were made to tie service outcomes to continued funding through the contract award and monitoring processes. It was recommended that agencies assessed to have high fidelity to evidence based practices be accredited as “Centers for Exemplary Practice” with accompanying financial incentives and regulatory relief. Some stakeholders suggested a monitoring continuum of compliance levels (e.g., minimal, recommended, and ideal) with associated financial consequences and incentives.

It was recommended that in looking at reported outcomes DMHS evaluate approaches to independent verification of outcome data submitted. For example, crosschecks on reported hospitalization with DMAHS, or crosschecks on reported employment, for example from state databases on employment taxes paid. DMHS should also examine financial models including managed care principles in relation to

promoting wellness and recovery services and ensure that no disincentives are inadvertently introduced into serving populations with characteristics expected to have poorer outcomes.

A well-established database of outcomes will enable DMHS to create a reader-friendly performance report card on programs, agencies, and hospitals. This report card should specify outcome data and should be published on the DMHS website.

Other Contracting and Regulatory Recommendations

A number of other regulatory suggestions were made:

- It was recommended that NJ Medicaid regulations be reviewed and where necessary and possible, DMHS should advocate for changes that remove obstacles to wellness and recovery services (e.g., changing from clinic to rehabilitation option services). In addition, to the review of Medicaid regulations, DMAHS should be involved in the transformation discussion.
- DMHS should provide financial incentives or regulatory relief for agencies who adopt EBPs.
- Practitioners and provider agencies should continue to be involved in the development of regulations and have input into whether the standards be minimum, recommended, or ideal so that the developing best practices and their experience with the consumer population will be appropriately reflected in the standards.
- Reviews of state policies should be conducted with provider input to establish standards and consequences.
- DMHS should planfully redirect resources from lesser-valued/lower priority to higher priority services. Funding should be available for pilot studies.
- Licensing regulations should be reviewed in terms of their friendliness or hostility to wellness and recovery approaches, Bureau of Licensing staff should be involved in these discussions.

- Reporting requirements should be reviewed for duplication of data submission. Duplication could be reduced by reviewing requirements from regulatory agencies.